PRINTED: 07/23/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/04/	ETED
	PROVIDER OR SUPPLIEI		•	6511 NE	DDDRESS, CITY, STATE, ZIP CODE EBRASKA DND, IN 46323	•	
(X4) ID PREFIX TAG W000000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
W000000	Dates of survey: 4, 2013 Facility number Provider numbe AIM number: 10 Survey Team: O Paul The following d state findings in 9.	r: 15G209 00234620 Christine Colon, QIDP-TC a Chika, QIDP eficiencies also reflect accordance with 460 IAC	WO	00000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00			COMPLETED	
		15G209	B. WING			06/04/2013	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6511 N	EBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE			OND, IN 46323		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000104	483.410(a)(1) GOVERNING BC The governing bo	DDY ody must exercise general					
	the facility.	nd operating direction over		00101			0= (0= (0=0.4.5)
		ew and record review for	W0	00104	The consumer will be reimbursed		07/05/2013
		nt (#3), the governing			the cost of the clippers \$17.12 by		
	body failed to ex	ercise general policy,			7/4/13. In addition Staff will be		
	budget and opera	ating direction over the			trained on taking the consumer out		
	facility to ensure the client did not purchase clippers for staff to cut the client's hair. Findings include:				to the barbershop for a hair cut on		
					an at least monthly basis. The Service coordinator will monitor		
					client finances to ensure none of		
					their money is spent on hair cuts or		
					other expenses that are included in the daily rate.		
	Client #1's finan	cial records were					
		3/13 at 5:58 AM. Client					
		cated client #3 purchased					
	•	•					
		rs) on 5/11/13 for \$17.12					
	at a local store.						
		taff #4 on 5/23/13 at 6:00					
		ient #3 purchased the					
	clippers. Staff#	4 indicated client #3 used					
	to go to a barber	and the clippers were at					
	the group home.						
	Interview with th	ne Service Coordinator					
	(SC) and admini	strative staff #2 on					
	` ′	PM indicated she was					
		ourchased clippers. The					
	_	group home staff called					
		nt #3 wanted to buy the					
		for his hair when they					
	were at the store	. The SC indicated she					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		15G209	A. BUI B. WIN	LDING IG		06/04/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
			6511 NEBRASKA				
	NORTHWEST IND			<u> </u>	OND, IN 46323		715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	had approved the	e purchase. When asked				•	
		l cut his own hair with					
		SC indicated facility staff					
		air. Administrative staff					
		f should not be cutting					
		and the client should be e community to get his					
	hair cut.	c community to get his					
	11411 041.						
	9-3-1(a)						
	,						

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Event ID: O3WL11

Facility ID: 000736

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		15G209	1			06/04/2013	
			B. WIN		ADDRESS CITY STATE OF CORE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
450.05	NODEL IMPORTANT	ANA INO THE			EBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE		HAIMIN	OND, IN 46323		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000111	483.410(c)(1)						
	CLIENT RECORI						
		develop and maintain a					
		stem that documents the					
		e, active treatment, social protection of the client's					
	rights.	ordection of the chefit's					
	•	review and interview for	l wo	00111	All Clients current physician		07/04/2013
	2 of 2 sampled clients (#1 and #2), the facility failed to ensure the clients' records		""	00111	orders will be filed in their chart by 7/4/13. Additionally, a release		07/01/2013
	•				form for libratory results has be	een	
	contained pertinent medical information				developed and made available	;	
	and/or clients' as	sessments.			electronically. This form		
					accompanies all consumers to)	
	Findings include	:			laboratory testing and for		
					hospitalizations to ensure the continuity of care between		
	1 A review of c	lient #1's record was			facilities. To ensure future		
		facility's administrative			compliance the service		
		3 at 2:29 P.M. Review of			coordinator will audit the file		
					during the first week of the mo		
		rd did not indicate any			for two months and periodicall	y	
		n's orders in client #1's			thereafter. July 3, 2013The		
	record.				current month's physician order are kept in a binder to docume		
					changes that occur during the	:111	
	Client #2's record	d was reviewed on			month. These orders will be fi	led	
	5/23/13 at 2:56 F	PM. Client #2's medical			in the individual client files with		
	record indicated	client #2 did not have			30 days of the close of the		
		ician's orders in his			following month. To ensure al		
	record.	101441 5 614015 111 1115			physician orders are accounte	d	
	record.				for, the Community Services		
	C1:	L.C. M. E. I.D I			Medical File Clerk will track an document physician orders	a	
		ulative Medical Record			sheets. The Director of Health	1	
		on 12/19/12 a PSA			Services will monitor clerk's	•	
	-	test) was done. Client			tracking to ensure		
	#2's Cumulative	records and/or chart			compliance.Each Monday the		
	indicated the resi	ults of the client's PSA			medical filling clerk will review	the	
	test was not part	of the client's medical			previous week's schedule for		
	record.				laboratory tests and		
	10001d.				hospitalization releases. She	will	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUILDING B. WING	00 	COMPLETED 06/04/2013			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
	(SC) and admini 5/24/13 at 1:38 I had the clients' p SC and administ the client's physilocated in the cli indicated the 12/routine laborator	ne Service Coordinator strative staff #2 on PM indicated the nurse hysician's orders. The rative staff #2 indicated cian's orders should be ent's record. The SC 19/12 PSA test was a y test that was done. The fourses) are looking for		submit a request for informatic for each document not receive and will maintain a log of these requests. The Director of Heat Services will monitor clerk's tracking to ensure compliance the service coordinator will audit the service coordinator will audit the file during the first week of the month for two months and periodically thereafter.	ed e ulth .To		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
	15G209	B. WING		06/04/2013		
NAME OF B	DOLUME DE ORGUNDA LER		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPPLIER	6511 NEBRASKA				
ARC OF	NORTHWEST INDIANA INC, THE	HAMMOND, IN 46323				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC!)	DATE		
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.					
	Based on observation and interview for 1	W000130	All staff will be trained on client	07/04/2013		
	of 2 sampled clients (#2), the facility		privacy and the preservation of			
	failed to ensure the client's privacy when		client dignity during treatment and			
	dressing.		care of personal need by 7/4/13. To			
	Findings include:		ensure that this practice continues, the service coordinator will visit the home three times a week until staff show proficiency in prompting and			
	During the 5/23/13 observation period		assisting clients in maintaining			
	between 5:50 AM and 8:35 AM, staff #4		privacy. Once proficiency is			
	knocked on client #2's bedroom door to		developed, monitoring will reduced			
	wake the client. Staff #2 left the bedroom		to bi monthly visits.			
	door open. Client #2 sat up and started to					
	dress with the door open, with staff #4 in					
	the room. Staff #4 did not close and/or					
	encourage client #2 to close the door.					
	Interview with the Service Coordinator					
	(SC) on 5/24/13 at 11:45 AM indicated					
	facility staff should close the door and/or					
	prompt clients to close the door when					
	dressing.					
	9-3-2(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15G209	B. WIN	G		06/04/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EBRASKA OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG W000186		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
W000180	care staff to mana accordance with plans. Direct care staff a	TAFF provide sufficient direct age and supervise clients in their individual program are defined as the present ulated over all shifts in a					
	24-hour period for each defined residential living unit.						
	_	ation, interview and	$ _{W0}$	00186	AM will be re-trained on workir	าต	07/04/2013
		r 2 of 2 sampled clients			with consumers and providing	•	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		for 2 additional clients			active treatment at this facility	and	
	,	facility failed to deploy			others that he supervises by	toff	
		t manner to meet the			7/4/13 so that he may assist st as deemed necessary. The	.ali	
		needs of the clients.			service coordinator will train w	ith	
	Findings include	:			return demonstrations and will observe AM working with each client. In addition, the electron time keeping system will be modified to monitor for the close.	n nic	
		13 observation period			in of both staff, on applicable	JK.	
		M and 8:35 AM, at the			shifts so that appropriate staffi	ng	
		re was one staff (staff #4)			can be established in the even		
	-	nts (#1, #2, #3 and #4)			scheduling difficulties. Are Are Managers required to work shi		
	•	ne group home at 5:50			that they fail to staff? Who is h		
		M, Area Manager (AM)			accountable when staff does n	not	
		r entering the group inounced he was the			show up? The Director will rev	iew	
		son for the morning shift.			audits of the house schedule weekly until an appropriate		
	•	ff #4 started waking			pattern of staffing is establishe	ed.	
	•	3 and #4 who were on the			Once established, monitoring v	will	
		group home. AM #1			fade to biweekly.July 3,2013 Area manager enters schedule	26	
		second (main level) of			into a computerized scheduling		
		in the kitchen/living room			system. The Area Manager w	ill	
		got up, dressed and went			run a manual "open shift" repo		
	_	m and sat down on the			on this home daily until all shift are full for the subsequent two		

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	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00	CHON	COMPLETED
	15G209	B. WING		06/04/2013
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS 6511 NEBRAS HAMMOND, II		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	2.112
	couch while AM #1 was in client #2's bedroom. At 6:40 AM, staff #4 started the morning medication pass with client #1, on the third floor lower level (basement). Clients #2, #3 and #4 sat in the living room without activity and/or training as the AM stood in the living room area. At 7:07 AM staff #4 was administering client #3's morning medications. AM #1 was on the main level of the group standing near the first level steps of the group home. Clients #1, #2 and #4 sat in the living room area without activity and/or training. At 7:20 AM, staff #4 returned to the main level of the group home and started setting the dining room table while clients #1, #2, #3, #4 sat in the living room waiting for breakfast. AM #1 stood in the dining room/kitchen area of the group home. Once the breakfast meal was done, client #2 stood to carry his dishes to the kitchen. AM #1 took the dishes from client #2. Staff #4 stated to AM #1 "[Client #2] is to rinse and put dishes in the dishwasher." AM #1 handed the dishes back to client #2. Client #4 took the trash out and client #3 swept the kitchen floor and wiped the dining room table off. Clients #1, #2 #3 and #4 did not participate in any additional training and/or activity during the morning observation period. After breakfast, staff #4 reminded and assisted clients #1, #2, #3 and #4 to brush their	full the ensure shifts report Direct mana running This strained report staff in home system is in the activation of the system o	k period. Once the shifts are report will be ran week are the following two weeks are fully staffed. These arts will be audited by the ctor daily until the area ager becomes proficient a sing them and then weekly system also has a "staffeed" monitoring system, this the will be ran each time as it is scheduled to work at the ending the process of being atted agency wide. As this em becomes active open arts will become automated attaff training reports to ensistaff are trained on the home.	dy to 's tt d is new nis ing nd s shift d as sure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		15G209	B. WING			06/04/	2013
NAME OF P	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					EBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMC	OND, IN 46323		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	teeth and comb t	heir hair. AM #1 stood					
	and/or sat in the	living room area as client					
	#4 shaved himse	lf with an electric razor					
	in the living roo	n without a mirror. AM					
	#1 did not redire	ct the client to shave in					
	the bathroom and	d/or in his room. Staff #4					
	was upstairs con	nbing client #2's hair in					
	the bathroom.	-					
	A review of clien	nt #1's record was					
	conducted on 5/2	23/13 at 2:29 P.M.					
	Review of the re	cord indicated a most					
		al Support Plan (ISP)					
		hich indicated the					
		I to (sic) identify signs in					
		.Will learn to identify					
	_	dicationsWill learn to					
	complete a hygie	ene check list.					
	Client #2's recor	d was reviewed on					
		PM. Client #2's 4/5/13					
		e client had objectives					
		e a communication					
	program (picture	•					
		system) to communicate					
		the group home, pour					
	juice/milk daily,	and an objective to sort					
	laundry.						
	A review of clien	nt #3's record was					
	conducted on 5/2	23/13 at 3:00 P.M.					
	Review of the re	cord indicated a most					
	current ISP dated	d 4/12/13 which indicated					
	the objectives: "	Will make a purchase in					
	· ·						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G209	B. WIN	G		06/04/2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
					EBRASKA	
ARC OF	NORTHWEST INDI	IANA INC, THE		HAMMC	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		and learn to count				
	~	ntinue to learn to do his				
	1	ontinue to clean his				
		earn to prepare a side				
	dishWill learn					
		l learn personal hygiene				
	tasks."					
	A review of client #4's record was conducted on 5/23/13 at 3:15 P.M. Review of the record indicated a most					
	current ISP dated	d 4/17/13 which indicated				
	the objectives: "	Will make change				
	combinations up	to 20 dollarsWill learn				
	to identify the na	ame of 1				
	medicationWil	l learn to prepare a				
	healthy side dish	• •				
	j					
	Interview with st	taff #4 on 5/23/13 at 6:00				
	AM indicated the	e group home was short				
		indicated she worked				
		urday night shift at the				
	_	regular basis as she				
	1 - 1	er group home. Staff #4				
	indicated she had	• •				
		C				
	_					
	_					
	morning sinit of	J 43 1J.				
	A review of the	facility's group home staff				
	additional hours the home being s indicated she did coming in as the morning shift of A review of the s actual clock in a	at the group home due to short staffed. Staff #4 I not know who was second staff person the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/04/2013
	PROVIDER OR SUPPLIE		6511 N	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	record indicated evening 4:00 P.1 1/1/13, 1/2/13, 1 1/7/13, 1/8/13, 1 1/14/13, 1/16/13 Interview with A AM indicated the of staff. AM #1 the group home died. AM #1 stated, " Interview with the (SC) on 5/24/13 staff worked in the even and the even are the second and the second are the seco	P.M. Review of the only 1 staff worked the M. to 11:00 P.M. shift on /3/13, 1/5/13, 1/6/13, /9/13, 1/10/13, 1/12/13, and 1/19/13. AM #1 on 5/23/13 at 6:34 he group home was short indicated the manager of quit and another staff. I'm second staff." The Service Coordinator at 11:25 AM indicated 2 the morning and 2 staff wening at the group home. d AM #1 was at the group he as a second staff as the not have another staff SC indicated the group short of staff. The SC It there should be two staff me during awake hours.			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			r í	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		15G209	B. WIN	3 <u> </u>		06/04/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			EBRASKA OND, IN 46323		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000189	with initial and co enables the empl duties effectively, competently. Based on observ interview the fac	orovide each employee intinuing training that oyee to perform his or her efficiently, and ation, record review and ility failed for 4 of 4	W00	00189	The S.C. will train all staff on client participation in meal preparation and running all the		07/04/2013
	#2, #3 and #4), to initial and ongoin clients' Individua	the group (clients #1, o provide staff with ng training on each al Support Plans (ISPs),			client goals when scheduled a at naturally occurring opportunities. To ensure that the practice continues the service coordinator in conjunction with	nd his	
		Sehavior Support Plans			the community service nurse will		
	the group home of P.M. until 6:30 F observation period entire meal which broccoli and che prompt or encourand #4 to participal preparation. State implement training and informal time #4 and #5 would check #4 but did not implement activities. Durin #5 asked staff #4	rvation was conducted at on 5/23/13 from 5:00			visit the home five times a wee until staff show proficiency in encouraging client participation meal preparation. Once proficiency is developed monitoring will reduce to bi monthly visits. July 3, 2013On proficiency is established monitoring will fade to two time per week, weekly, and then Biweekly. Additional, monitorine events will be added if staff changes occur. 7/16/13 addendum corrections- this replaces the old plan "The S.C. will train all staff on client participation in meal preparation and running all the client goals when scheduled a at naturally occurring opportunities. To ensure that the practice continues the service coordinator in conjunction with the community service nurse we until staff show proficiency in	ek n in ce es ng nd his	

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Event ID: O3WL11

Facility ID: 000736

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ì ′		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G209	B. WIN			06/04/2013
NAME OF P	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					EBRASKA	
ARC OF	NORTHWEST INDI	IANA INC, THE		HAMMO	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	•	DATE
	work at this grou	ip nome often.		encouraging client participation in meal preparation and running	1 111	
					goals. Once proficiency is	
		nt #1's record was			established monitoring will	
		23/13 at 2:29 P.M.			fade to two times per week,	
		cord indicated a most			weekly, and then Biweekly.	
		al Support Plan (ISP)		Additional, monitoring events will be added if staff changes		
	dated 2/14/13 wi	C				
	objectives: "Will to (sic) identify signs in the communityWill learn to identify					
	names of his medicationsWill learn to					
	complete a hygiene check list." Review					
	of client #1's rec					
	_	ed, but was not limited to,				
		nia. The record indicated				
		plan dated 1/13 and a				
	dining plan for c	hoking risk dated 1/13.				
	Client #2's recor	d was reviewed on				
	5/23/13 at 2:56 I	PM. Client #2's 4/5/13				
	Hygiene Plan (ri	sk plan) indicated "				
	[Client #2] is at a	risk of infection from				
	poor hygiene hal	bits. History: [Client #2]				
	was hospitalized	in August 2012 with an				
	infection stemmi	ing from poor hygiene				
	habits" The 4	/5/13 plan indicated				
	client #2 would i	not wash his hands after				
	using the bathroo	om and/or scratch his				
	buttocks with his	s hands and not wash his				
	hands afterwards	s. Client #2's plan				
	indicated "[Cli	ent #2] will use hand				
	sanitizer before a	and after every meal to				
	ensure hands are	sanitary"				
	Client #2's 4/5/1	3 Individual Support Plan				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		00	COMI	e survey Pleted 4/2013
ANA INC. THE	STREET A	EBRASKA	CODE	
ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
ient #2 had the	IAU	DEFERRET		DATE
a communication sicture exchange system) to communicate this own juice and milk Cclient #2's record moses included, but were rpical psychosis, rder, kyphosis-scoliosis, isorder, diabetes, GERD all reflux disease). It #3's record was 3/13 at 3:00 P.M. ord indicated a most 4/12/13 which indicated Will make a purchase in ad learn to count tinue to learn to do his natinue to clean his arn to prepare a side the six rights of				
	DENTIFICATION NUMBER:	DENTIFICATION NUMBER: 15G209 ANA INC, THE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ient #2 had the ves which were not en opportunities for to his mouth for oral a communication ieture exchange ystem) to communicate his own juice and milk Cclient #2's record noses included, but were epical psychosis, rder, kyphosis-scoliosis, isorder, diabetes, GERD al reflux disease). t #3's record was 3/13 at 3:00 P.M. ord indicated a most 4/12/13 which indicated Will make a purchase in and learn to count tinue to learn to do his nitinue to clean his arn to prepare a side the six rights of learn personal hygiene	DENTIFICATION NUMBER: 15G209 A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP 6511 NEBRASKA HAMMOND, IN 46323 THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE PROVIDERS PLANDER ROSS-REFER	DENTIFICATION NUMBER: 15G209 A BUILDING 8 WING STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323 ANA INC, THE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) SIENT #2 had the ves which were not en opportunities for to his mouth for oral a communication sicture exchange ystem) to communicate his own juice and milk Cclient #2's record noses included, but were pical psychosis, storder, diabetes, GERD al reflux disease). #3's record was 3/13 at 3:00 P.M. ord indicated a most 4/12/13 which indicated Will make a purchase in dd learn to count tinue to learn to do his ntinue to clean his arm to prepare a side he six rights of learn personal hygiene

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		(X2) MULTIPLE C	OO OOO	COM	E SURVEY PLETED 14/2013	
NAME OF P	ROVIDER OR SUPPLIER			TADDRESS, CITY, STATE, ZIP ONEBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE	HAMN	MOND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	not limited to, ep	gnosis included, but was bilepsy with recurrent NS unit (Vagal nerve izures).				
	conducted on 5/2 Review of the recurrent ISP dated the objectives: "combinations up to identify the namedicationWill healthy side dish review of the recidiagnoses include to, diabetes, card psychosis. A review of the section list was considered as a second side of the section of the sec	l learn to prepare a for dinner." Further ord indicated his ed, but were not limited liovascular disease and group home staff and inducted on 5/23/13 at w of the list did not as a scheduled staff for				
	An interview wit	th the Service				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G209	A. BUILDING	00	COMPLETED 06/04/2013
		150209	B. WING		00/04/2013
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE EBRASKA	
ARC OF	NORTHWEST IND	DIANA INC, THE		OND, IN 46323	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
ing		C) was conducted at the	IAG	·	DATE
	` `	istrative office on 5/24/13			
	I -	The SC indicated the			
		submitted were all of the			
		she had to submit for			
	review. The SC	further indicated all staff			
		ed on each client's			
	1	to working with the clients			
		ne. No documentation			
		for review to indicate each			
		aining on each client's oral and medical needs.			
	i uaining, benavi	orar and medical needs.			
	9-3-3(a)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G209	A. BUII B. WIN			06/04/	2013
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIEF	2	6511 NEBRASKA				
ARC OF	NORTHWEST IND	IANA INC, THE	HAMMOND, IN 46323				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG W000217	483.440(c)(3)(v) INDIVIDUAL PRO The comprehens must include nutr Based on record facility failed to for 1 of 2 sample Findings include A review of clie conducted on 5/2 Review of the re was admitted to Further review of indicate client # needs had been a An interview wi Coordinator (SO facility's administ at 11:25 A.M. T facility's nursing	or ive functional assessment ritional status. review and interview the assess the dietary needs red clients (client #1). The control of the facility on 1/18/13. The facility on 1/18/13.	W0	TAG 00217	A dietary assessment will be schedule by 7/4/13 for client #1 and any other client in need of an assessment. To ensure future compliance the service coordinator will audit the file weekly until all assessments are completed and then quarterly thereafter.		07/04/2013

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUII	LDING	ONSTRUCTION 00	(X3) DATE S COMPLI 06/04/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE EBRASKA OND, IN 46323		
(X4) ID PREFIX	SUMMARY S	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION
TAG W000220	483.440(c)(3)(v) INDIVIDUAL PRO	ve functional assessment		TAG	DEFICIENCY)		DATE
	development. Based on observer record review for (#1 and #2), the compreh assessments failed had obtained specific properties of the compreh assessments failed had obtained specific properties.	ation, interview and r 2 of 2 sampled clients densive functional ed to indicate the facility ech/communication the clients' language	W0	00220	Speech and language Assessments will be scheduled by 7/4/13 for client #1 and #2 and any other clier in need at this home. Recommendations, will be integrated into the individuals IPP and goals developed as appropriate Once scheduled this appointment		07/04/2013
	skills/abilities. Findings include 1. During the 5/2 between 5:50 AM group home, clie				and its follow up appointments will be maintained in an annual schedu of required appointments by the Health Care Manager. To ensure future compliance the service coordinator will audit the file week until all assessments are completed and then quarterly thereafter.	le	
	the group home of P.M. until 6:30 F observation, clies communication is speak. Client #1 understood when A review of clies conducted on 5/2 Review of the rewas admitted to the second conducted on 5/2 conducted cond	nt #2 was non-verbal in n that the client did not was not able to be					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		15G209	A. BUI B. WIN	LDING		06/04/	
N. M. C.	DOMEST OF COMME		D. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
	ROVIDER OR SUPPLIER			6511 NE	EBRASKA		
ARC OF	NORTHWEST INDI	ANA INC, THE		HAMMC	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		al Support Plan (ISP)		1110			5.112
		d/or record did not					
		nt's speech and/or					
		ad been assessed.					
		d was reviewed on					
	5/23/13 at 2:56 PM. Client #2's 1/18/12						
	_	Assessment indicated the					
		ted to the group home on #2's 4/5/13 ISP and/or					
		dicate the client's speech					
		skills had been assessed.					
	and/or ranguage	skins had been assessed.					
	Interview with th	ne Service Coordinator					
	(SC) and admini	strative staff #2 on					
	5/24/13 at 1:38 I	PM indicated no speech					
	assessments coul	ld be located for clients					
	#1 and #2.						
	9-3-4(a)						
	9-3-4(a)						

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STATEMEN	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
	15G209	B. WING		06/04/2013		
NAME OF B	DOLUDED OF GUIDNIED		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER	6511 N	EBRASKA			
ARC OF	NORTHWEST INDIANA INC, THE	HAMMOND, IN 46323				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
W000221	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include auditory functioning. Based on interview and record review for 1 of 2 sampled clients (#2), the facility failed to ensure the client's hearing had been assessed. Findings include: Client #2's record was reviewed on 5/23/13 at 2:56 PM. Client #2's 4/5/13 Individual Support Plan (ISP) and/or record did not indicate client #2's hearing had been assessed since the client was admitted to the group home in 11/30/94. Interview with the Service coordinator (SC) and administrative staff #2 on 5/24/13 at 1:38 PM indicated they were not able to locate a hearing/audiological assessment for client #2.	W000221	An auditory functioning assessment will be scheduled by 7/4/13 for client #2 and any other client in need at this home. Recommendations will be integrate into the individuals IPP and goals developed as appropriate. Once scheduled this appointment and its follow up appointments will be maintained in an annual schedule or required appointments by the Health Care Manager. To ensure future compliance the service coordinator will audit the file week until all assessments are completed and then quarterly thereafter.	07/04/2013 ad		
	9-3-4(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15G209	B. WIN			06/04/	2013
CE OF P				STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			6511 N	EBRASKA		
	NORTHWEST INDI	ANA INC, THE		HAMM	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000249	483.440(d)(1) PROGRAM IMPL	EMENTATION					
		terdisciplinary team has					
		nt's individual program plan,					
		receive a continuous active					
		n consisting of needed					
		services in sufficient					
		uency to support the ne objectives identified in					
	the individual pro						
		ation, interview and	W0	00249	The S.C. will train all staff in		07/04/2013
	record review for	r 2 of 2 sampled clients			running all the client goals who	en	
	(clients #1 and #	2), and 2 additional			scheduled and at naturally		
	· ·	3 and #4), the facility			occurring opportunities. The service coordinator will model		
	•	ent the clients' program			appropriate implementation of		
	-	when formal and/or			goals, and will provide training		
		g opportunities existed.			until proficiency is established.		
	mirormar tramme	s opportunities existed.			To ensure that this practice		
	Findings include				continues the service coordina		
	rindings include	•			will visit the home three times week until staff show proficient		
	1 During the 5/	22/12 absorpation named			in running and documenting	. ,	
	•	23/13 observation period			goals. Once proficiency is		
		M and 8:35 AM, at the			developed monitoring will redu	ice	
		ent #2 did not wash his			to bi monthly visits. July 3, 2013Once proficiency is		
	•	ting breakfast. Staff #4			established monitoring will fad	e to	
		nager (AM) #1 did not			two times per week, weekly, a		
	_	r prompt the client to			then Biweekly. Additional,		
	wash his hands o	or to use hand sanitizer.			monitoring events will be adde		
		of the group home, a			staff changes occur. 7/16/13 T		
	sign was posted	above the desk area			replaces old plan of correction "The S.C. will train all staff on		
	which indicated	client #2 was to wash his			client participation in meal		
	hands after toilet	ing and before meals.			preparation and running all the	,	
	Also during the	5/23/13 observation			client goals when scheduled a		
	_	taff #4 poured hot water			at naturally occurring		
		cup for coffee, poured the			opportunities. To ensure that to practice continues the service	nis	
		o a cup and custodially			coordinator in conjunction with	1	
		client #2's cup without			the community service nurse v		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE S COMPL		
		15G209		LDING		06/04/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EBRASKA		
ARC OF	NORTHWEST IND	ANA INC, THE		HAMMO	OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		ng the client. Client #2	+	TAG	visit the home five times a wee		DATE
	_	training and/or activity			until staff show proficiency in	,	
		13 observation period			encouraging client participation	n in	
	_	was waiting for breakfast.			meal preparation and running goals. Once proficiency is		
		breakfast was over, the			established monitoring will		
	client sat in the living room area without an activity and/or training except where staff #4 took client #2 to the bathroom to comb his hair. Staff #4 did not provide				fade to two times per week,		
					weekly, and then Biweekly. Additional, monitoring event	_	
					will be added if staff changes		
					occur."		
	any medication training with client						
	#2 during the morning medication pass.						
	_	e mentioned 5/23/13					
	observation perio						
		mmunication in that the					
	_	eak. Staff did not provide					
	client.	ion training with the					
	CHCIII.						
	An evening obse	ervation was conducted at					
	the group home	on 5/23/13 from 5:00					
	P.M. until 6:30 I	P.M During the					
		od, Staff #4 cooked the					
		h consisted of tacos and					
		rice. Staff #4 did not					
		rage clients #1, #2, #3					
		pate in meal preparation.					
		lid not implement					
		es at formal and informal					
		nity. Staff #4 and #5 clients #1, #2, #3 and #4					
		ement meaningful					
	activities.	mont moaningrai					
	A review of clien	nt #1's record was					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G209	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/04	LETED
NAME OF 1	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODI		
ARC OF	NORTHWEST INDI	ANA INC, THE			EBRASKA DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Review of the recurrent Individual dated 2/14/13 who bjectives: "Will the community names of his mecomplete a hygien Client #2's record 5/23/13 at 2:56 Hygiene Plan (ri [Client #2] is at a poor hygiene hal was hospitalized infection stemmin habits" The 4 client #2 would a using the bathrood buttocks with his hands afterwards indicated "[Client #2's 4/5/1 (ISP) indicated consure hands are Client #2's 4/5/1 (ISP) indicated consumption object implemented who training existed:	d was reviewed on PM. Client #2's 4/5/13 sk plan) indicated " risk of infection from bits. History: [Client #2] in August 2012 with an ng from poor hygiene /5/13 plan indicated not wash his hands after om and/or scratch his shands and not wash his sc. Client #2's plan ent #2] will use hand after every meal to sanitary" 3 Individual Support Plan lient #2 had the ives which were not en opportunities for					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G209	B. WIN			06/04/	2013
NAME OF B	DROVIDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	C		6511 N	EBRASKA		
ARC OF	NORTHWEST IND	IANA INC, THE		HAMMO	OND, IN 46323		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	FIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX			COMPLETION
TAG			_	TAG	DEFICIENCY)		DATE
	communication system) to communicate daily." -To learn to pour his own juice and milk daily.						
	A review of client #3's record was conducted on 5/23/13 at 3:00 P.M.						
	Review of the re	cord indicated a most					
	current ISP dated	d 4/12/13 which indicated					
	the objectives: "Will make a purchase in						
	the community and learn to count						
		ntinue to learn to do his					
	_	ontinue to clean his					
	1	earn to prepare a side					
	dishWill learn	• •					
		Il learn personal hygiene					
	tasks."	n learn personal hygiene					
	tasks.						
	A review of clien	nt #4's record was					
	conducted on 5/2	23/13 at 3:15 P.M.					
		cord indicated a most					
		d 4/17/13 which indicated					
		Will make change					
	-	to 20 dollarsWill learn					
	to identify the na						
	1	ll learn to prepare a					
	healthy side dish	i ioi ullillei.					
	Interview with +1	ne Service Coordinator					
	` '	13 at 1:38 PM indicated					
		uld implement clients'					
	goals throughout	t the day.					
	2. During the 5/	23/13 observation period					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUILDING B. WING	COMPLETED 06/04/2013			
	ROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)	LD BE COMPLETION			
	between 5:50 AM and 8:35 AM, at the group home, staff #4 did not provide any medication training with client #1 at the morning medication pass.					
	Client #1's record was reviewed on 5/23/13 at 2:29 P.M. Client #1's 2/14/13 ISP indicated client #1 had an objective to learn to identify names of his medications which facility staff did not implement. Interview with the Service Coordinator (SC) #1 on 5/24/13 at 1:38 PM indicated facility staff should implement clients' goals throughout the day. 9-3-4(a)					

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Event ID: O3WL11

Facility ID: 000736

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/04/2013	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W000368	assure that all dricompliance with the Based on observing record review for administered, the a client's medical prescribed for client's medical prescribed for client findings included. During the 5/23/between 5:50 All received his more AM. Client #3 or Pre Moist Pad at pass. Client #3's May Administration Is reviewed on 5/2: #3's May 2013 As should receive County the morning "Use Client #3's recort 5/23/13 at 3:56 Is physician's order received "Ocusor directed by doctor An interview with the complete state of the properties of the state of the physician's order received "Ocusor directed by doctor and the properties of the physician's order received "Ocusor directed by doctor and the properties of the physician's order received "Ocusor directed by doctor and the properties of the physician's order received "Ocusor directed by doctor and the properties of the physician's order received "Ocusor directed by doctor directed	rug administration must rugs are administered in the physician's orders. ation, interview and r 1 of 22 medications e facility failed to ensure tion was administered as ient #3. 13 observation period M and 8:35 AM, client #3 ming medications at 7:08 did not receive Ocusoft the morning medication 2013 Medication Record (MAR) was 3/13 at 8:10 AM. Client #3 ocusoft Pre-Moist Pad in e as directed" daily. d was reviewed on PM. Client #3 indicated client #3 ft Pre-Moist Pads Use as ft Pre-Moist Pads Use as	Wo	00368	This staff and other staff working at this home will be retrained on medication administration by 7/4/3 including the administration of Acusoft. To ensure that this practic continues the service coordinator and community services nurse will visit the home five times a week including weekends and will observe medication passes, until staff show proficiency in administering and documenting medications. Once proficiency is developed monitoring will reduce to bi monthly visits.	ee ve	07/04/2013

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PRINTED: 07/23/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUILDING B. WING	COMPLETED 06/04/2013					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Pad she stated, "indicated the Oc	d the Ocusoft Pre-Moist Missed giving." Staff #4 usoft was a scrub which d to client #3's eyelids.						
	9-3-6(a)							

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Event ID: O3WL11

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE (COMPL 06/04 /	ETED	
	PROVIDER OR SUPPLIER		J. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE EBRASKA DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000440	least quarterly for Based on record facility failed to on the day shift (during the third of September 30th) of 4 clients living #1, #2, #3 and #4). Findings include A review of the conducted on 5/2 review failed to an evacuation drand #4 on the da quarter of 2012. The Area Managon 5/22/13 at 11 indicated all available had been submit An interview with Coordinator (SC 5/24/13 at 11:25 evacuation drills	facility's records was 22/13 at 11:37 A.M. The indicate the facility held ill for clients #1, #2, #3 y shift during the day.	Woo	00440	A Day shift fire drill will be held by 7/4/13. All staff will be trained on running fire drills per regulation. To ensure future compliance the Director will audit fire drill logs on the third week of each month and will schedule the AM to run an unannounced fire drill during any missing shifts during the fourth week of the month. Once a regular pattern of drills is established monitoring will fade to a quarterly basis, still occurring on the third week of the month so that any missing drills can be run.		07/04/2013

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PRINTED: 07/23/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G209	A. BUILDING B. WING	00	СОМ	E SURVEY PLETED 4/2013		
ARC OF	ROVIDER OR SUPPLIER	IANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETI			TED	
		15G209	B. WIN			06/04/2	.013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			EBRASKA		
ARC OF	NORTHWEST INDI	IANA INC, THE			OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000455	483.470(I)(1)	ITPO					
	INFECTION CON	n active program for the					
		ol, and investigation of					
		nmunicable diseases.					
	Based on observ	ation, interview and	W0	00455	This staff and other staff working at		07/04/2013
		r 2 of 2 sampled clients			this home will be retrained on hand		
	(#1 and #2), and for 2 additional clients				washing and universal precautions		
	` ' '	facility failed to ensure			by 7/4/13. To ensure that this		
	clients washed their hands prior to eating				practice continues the service		
	to prevent the po				coordinator and community services		
	infection.	and a partial of			nurse will visit the home five times a week including weekends and will	1	
	micetion.				observe medication passes and mea	.	
	Pin Paradical day				preparation, until staff show	"	
	Findings include	·			proficiency in hand washing and		
	D	12 -1			sanitation. Once proficiency is		
	_	13 observation period			developed monitoring will reduce to		
		M and 8:35 AM, at the			bi monthly visits.		
		ents #1, #2, #3 and #4 did					
		ands nor did they use					
	_	rior to eating breakfast.					
	Staff #4 and/or A	Area Manager (AM) #1					
	did not encourag	ge and/or prompt the					
	clients to wash th	heir hands. In the office					
	area of the group	home, a sign was posted					
	-	rea which indicated client					
		nis hands after toileting					
	and before meals	•					
	An evening obse	ervation was conducted at					
	_	on 5/23/13 from 5:00					
		P.M. From 5:00 P.M.					
		clients #1, #2, #3 and #4					
	sat in the living						
		mach several times.					
	Client #1 wiped	his nose with his bare					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		15G209	B. WIN			06/04/2013
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			6511 N	EBRASKA	
	NORTHWEST IND	IANA INC, THE		HAMMO	OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	ì ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION) D.M. alignets #1 #2 #2		TAG	32.102.101	DATE
		P.M., clients #1, #2, #3				
	_	mpted by staff #4 to eat				
		#1, #2, #3 and #4 walked				
		rea and sat down and				
	-	emselves. Clients #1, #2,				
		and were not prompted				
		nds nor to use hand				
	sanitizer prior to eating their evening					
	meal.					
	Client #2's record was reviewed on					
	5/23/13 at 2:56 PM. Client #2's 4/5/13					
	Hygiene Plan (ri	sk plan) indicated "				
	[Client #2] is at:	risk of infection from				
	poor hygiene hal	bits. History: [Client #2]				
	was hospitalized	in August 2012 with an				
	infection stemm	ing from poor hygiene				
	habits" The 4	/5/13 plan indicated				
	client #2 would	not wash his hands after				
	using the bathro	om and/or scratch his				
	buttocks with his	s hands and not wash his				
	hands afterwards	s. Client #2's plan				
		ent #2] will use hand				
	_	and after every meal to				
		sanitary" The risk				
		cility staff would monitor				
		gns of poor hygiene."				
		, 1 50				
	Interview with the	ne Service Coordinator				
		at 1:38 PM stated client				
	` /	rith infection," and the				
		sh his hands "throughout				
		C indicated facility staff				
	1	ouraged client #2 to wash				
	Should have eller	ouraged ellerit #2 to wash				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G209		A. BUILDING B. WING	COMPLETED 06/04/2013					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	client #2 was ho	e meal. The SC indicated spitalized in the past with to the client's poor						
	9-3-7(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		15G209	B. WING 06/04/20			013	
NAME OF B	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			6511 N	EBRASKA		
	NORTHWEST INDI				OND, IN 46323		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
W000460	Each client must well-balanced die specially-prescrib	RITION SERVICES receive a nourishing, t including modified and ed diets. ation, interview and	Wo	00460	A dietary assessment will be		07/04/2013
		r 1 of 2 sampled clients	"	00100	schedule by 7/4/13 for client #		07/04/2015
		acility failed to assure the			and any other client in need of		
	` '	od in accordance with the			assessment. Once completed	l,	
	client's diet order				the dietician will modify the me	I .	
	chem's diet order	l.			to reflect accurate measurements at each meal. Nursing staff will		
	Findings include	:			have trained staff on the diabe diets. In order to prevent reoccurrence the Nurse in	I .	
	During the 5/23/	13 observation period			conjunction with the service		
	between 5:50 AN	M and 8:35 AM, at the			coordinator will train both hom	-	
	group home at 6:	32 AM, the facility had a		and day program on the diabetic			
	2000 (calorie) A	DA (diabetic) diet posted			diet plan, this training will inclu a demonstration on making	ide	
		nich was undated and did			exchanges and identifying		
		ly date for which day the			appropriate day time snacks		
		ld be served. The menu			including modeling and return		
		pecify portion sizes. The			demonstrations of appropriate		
		nenu also did not indicate			exchanges. A set of measured service utensils will be obtained	I .	
	•	wed/signed the menus.			for this home and Cl# 2 will be	-	
		diet menu indicated the			trained on utilizing them To		
	following:	aret mena mareatea the			ensure that this practice		
	ionowing.				continues the service coordina		
	regular diet:				and community services nurse will visit the home five times a	·	
	•				week including weekends and	will	
	pineapple				observe medication passes an	nd	
	Canadian bacon				meal preparation, until staff sh		
	toast				proficiency in hand washing ar		
	margarine				sanitation. Once proficiency is developed monitoring will redu		
	Orange juice				to bi monthly visits. July 3, 20		
	Water				"until staff show proficiency in		
					hand washing and sanitation."		
	2000 diabetic die	et:			Should read "until staff show		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	A. BUILDING 00 COMPLETED		
		15G209	A. BUI. B. WIN			06/04/2013
			p. ,,		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		1	EBRASKA	
ARC OF	ARC OF NORTHWEST INDIANA INC, THE				OND, IN 46323	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	,	DATE
	pineapple				proficiency in following the prescribed diet, measurements	
	sausage patty				and appropriate food exchang	
	toast					
	1 cup 2% milk					
	water					
	margarine					
	During the 5/23/	/13 observation period,				
	clients #1, #2, #3 and #4's breakfast was					
	fixed by staff #4. Staff #4 prepared and					
	served the same food and/or serving					
		h client. Clients #1, #2,				
		yed 1 hard boiled egg,				
		t Crunch cereal, raisin				
	bread toast with	· ·				
	`	late spread) on it				
	`	nount), 1 cup of coffee, 1				
		et, 1 cup of milk and 1 cup				
	of water.					
	An evening obse	ervation was conducted at				
	the group home	on 5/23/13 from 5:00				
	P.M. until 6:30 l	P.M. At 5:45 P.M., client				
	#2 began eating	his evening meal which				
		meat, tortillas, lettuce,				
		coli-cheese rice. Client #2				
	served himself 2					
		neat in each tortilla and an				
	_	ount of rice. After client				
		staff #4 asked client #2 if				
	· · · · · · · · · · · · · · · · · · ·	food. Client #2 then				
		nother tortilla with an				
		ount of meat and rice.				
	After client #2 f	inished his second				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G209	A. BUILDING 06/04/2013				
		100200	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/04/20	10
NAME OF P	PROVIDER OR SUPPLIER			1	EBRASKA		
	NORTHWEST INDI				DND, IN 46323		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) OMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE CC	DATE
	helping of the m	eal, he walked to the					
	living room. Sta	ff #4 again asked client					
	#2 if he wanted 1	more food. Client #2					
	walked into the l	citchen and served					
	himself the rema	ining taco meat and rice					
	in the serving bo	wls.					
	Client #2's recor	d was reviewed on					
	5/23/13 at 2:56 I	PM. Client #2's 5/13					
	physician's orders indicated client #2's						
	diagnosis included, but was not limited to,						
	` • •	I). Client #2's 5/13					
		rs indicated client #2					
		calorie diabetic, low					
	cholesterol diet.						
	Client #2's 8/17/	11 Nutritional					
	Assessment was	reviewed on 5/23/13 at					
	2:56 P.M. The N	futritional Assessment					
		#2 received a 2000 calorie					
	low fat and low	cholesterol diet.					
	Interview with the	ne Service Coordinator					
	(SC) and admini	strative staff #2 on					
	5/24/13 at 1:38 I	PM indicated client #2					
	was on a 2000 ca	alorie diabetic diet. The					
		ility staff should follow					
	•	in the group home. The					
		rative staff #2 indicated					
	_	e to turn in menus					
	· ·	viewed and signed by the					
	dietician.						
	9-3-8(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
ANDILAN	OI CORRECTION	15G209	A. BUILDING	00	06/04/2013		
			B. WING	ADDRESS CITY STATE ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA				
ARC OF	NORTHWEST IND	IANA INC, THE		OND, IN 46323			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DLI ICILI C I)	DATE		

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Event ID: O3WL11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
		15G209	B. WING		06/04/2013
NAME OF E	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIE	r.	6511 N	EBRASKA	
ARC OF	NORTHWEST IND	DIANA INC, THE	HAMM	OND, IN 46323	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W000488	483.480(d)(4) DINING AREAS	AND SERVICE			
		assure that each client eats			
	in a manner cons	sistent with his or her			
	developmental le		W000488		
		Based on observation and interview, the		The S.C. will train all staff on client	07/04/2013
	1	assure 4 of 4 clients		participation in meal preparation	
		group home (clients #1, #2,		and running all the client goals whe	
	· · · · · · · · · · · · · · · · · · ·	e involved in meal		scheduled and at naturally occurring opportunities. To ensure that this	B
	preparation and	served themselves at meal		practice continues the service	
	times as indeper	ndently as possible.		coordinator in conjunction with the	
				community service nurse will visit	
	Findings include	e:		the home five times a week until	
				staff show proficiency in	
	During the 5/23	/13 observation period		encouraging client participation in	
	between 5:50 A	M and 8:35 AM, at the		meal preparation. Once proficiency is developed monitoring will reduce	
	group home, sta	ff #4 custodially prepared		to bi monthly visits.	
	breakfast while	clients #1, #2, #3 and #4		lo of monthly visits.	
		room. Staff #4 set the			
	I -	ng room, made raisin			
	bread toast, plac				
	· *	late) Spread on the toast,			
	`	to the table, made coffee,			
		poiled eggs without			
		ients. Staff #4 poured hot			
		ient's cup and added			
		nd placed 1 sweetener			
		lient's place setting at the			
	1 *	ooured cereal into clients			
	_	vls. Staff #4 retrieved a			
		or each client from the			
	~	eeled the hard boiled eggs			
	_				
		gg on each client's plate.			
	_	milk into each client's cup			
	at the dining roo	om table. Staff #4 also	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		15G209	B. WING			06/04/	2013
	PROVIDER OR SUPPLIE		65	11 NE	DDRESS, CITY, STATE, ZIP CODE EBRASKA DND, IN 46323		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREI TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		alad for client #1, #2, #3 vithout involving the					
	the group home P.M. until 6:30 I observation perientire meal which broccoli-cheese prompt or encourand #4 to participare paration. Client #2's recons 5/23/13 at 2:56 I Individual Supposition of the reconducted on 5/2 Review of the recurrent ISP date indicated: "Will dish." A review of clie conducted on 5/2 Review of the recurrent ISP date indicated: "Will dish."	ervation was conducted at on 5/23/13 from 5:00 P.M. During the od, staff #4 cooked the ch consisted of tacos and rice. Staff #4 did not trage clients #1, #2, #3 apate in mealtime rd was reviewed on PM. Client #2's 4/5/13 ort Plan (ISP) indicated objective to, with staff at to pour juice/milk daily. Int #3's record was 23/13 at 3:00 P.M ecord indicated a most d 4/12/13 which learn to prepare a side and the staff P.M ecord indicated a most d 4/17/13 which learn to decord indicated a most d 4/17/13 which					
	healthy side dish	l learn to prepare a n for dinner."					

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		IDENTIFICATION NUMBER: 15G209	A. BUILDING B. WING	00	COMPLETED 06/04/2013		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 6511 NEBRASKA HAMMOND, IN 46323				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	(SC) on 5/24/13 clients #1, #2, #3 table and be invo	ne Service Coordinator at 11:25 AM indicated 3 and #4 should set the olved in meal preparation.					
	9-3-8(a)						

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